

JEFFERSON COUNTY COMMISSION

UNPAID LEAVE POLICY

ADMINISTRATIVE ORDER

07-2

AMENDED DECEMBER 14, 2010

ADMINISTRATIVE ORDER
OF THE
JEFFERSON COUNTY COMMISSION
07-2
Amended December 14, 2010

Pursuant to the authority vested in the Jefferson County Commission by law, the following Administrative Order is hereby issued:

PURPOSE

To establish a policy for compliance with the Family and Medical Leave Act ("FMLA"), of 1993, as amended, 29 C.F.R. Part 825, the Uniform Services Employment and Reemployment Rights Act ("USERRA"), §§ 31-2-13 and 31-12-6, Alabama Code (1975), the Jefferson County Commission's January 27, 2004 Resolution (Minute Book 143, Pages 556-557) establishing the War on Terrorism Supplemental Military Benefit, the Personnel Board of Jefferson County Enabling Act, Alabama Act 248 (1945), as amended, and the Rules and Regulations of the Personnel Board of Jefferson County which relate to unpaid leaves of absence for employees of Jefferson County, and to establish procedures for the following:

1. The receipt, review, approval, disapproval and retention of all requests for unpaid leaves of absence by the Director of the Human Resources Department;
2. The continuation of employment benefits for employees on an approved unpaid leave of absence;
3. The return to duty of employees on an approved unpaid leave of absence; and
4. The substitution of workers' compensation leave and other forms of paid leave for FMLA Leave to the fullest extent that the FMLA allows such substitution.

I. POLICY

It shall be the policy of the Jefferson County Commission to comply with all federal and state laws and the Rules of the Personnel Board of Jefferson County which relate to

the unpaid leaves of absence of Employees of Jefferson County. The Jefferson County Commission hereby delegates its authority to approve unpaid leaves of absence to the Director of the Human Resources Department as permitted by § 19, Alabama Act 248 (1945), as amended. It shall also be the policy of the Jefferson County Commission that all forms of paid leave be substituted for FMLA Leave to the fullest extent that the FMLA allows such substitution.

II. IMPLEMENTATION DATE

This Administrative Order is effective on the date specified by Paragraph XIII, below, and it shall apply to all new requests for unpaid leaves of absence and all requests for unpaid leaves of absence that are pending on such effective date and all requests for extension or modification of previously approved unpaid leaves of absence submitted or pending on or after such effective date.

III. DEFINITIONS

For purposes of this Administrative Order, the following terms, whether in the singular form or the plural form, shall have the following meanings when used herein:

- A. **Administrative Leave Without Pay.** "Administrative Leave Without Pay" means leave without pay authorized by Personnel Board Rule 13.20.
- B. **AWOL.** "AWOL" means that an Employee is absent from work without eligibility for paid leave and without approved Unpaid Leave.
- C. **Career Development Leave.** "Career Development Leave" means leave without pay authorized by Personnel Board Rule 13.18(a)(2) to engage in a course of study which will contribute materially to the Employee's value to Jefferson County.

D. **Child.** "Child" means, for FMLA purposes, any person who is under 18 years old, or any person 18 years old or older who is incapable of self-care because of a mental or physical disability, whose relationship to an Employee is that of a biological child, an adopted child, a stepchild, a legal ward, or a child placed for foster care or as to whom an Employee stands in loco parentis.

E. **Classified Employee.** "Classified Employee" means a person appointed for employment in the classified service.

F. **Covered Active Duty.** In the case of a member of a regular component of the Armed Forces, duty during the deployment of the member with the Armed Forces to a foreign country and in the case of a member of a reserve component of the Armed Forces, duty during the deployment of the member with the Armed Forces to a foreign country under a call or order to active duty.

G. **Director.** "Director" means the Director of the Human Resources Department of Jefferson County.

H. **Employee.** "Employee" means all Employees of Jefferson County, whether classified or unclassified. The definition of "Employee" does not include any Elected Official or any person appointed to fill a vacant elected position.

I. **Extended Medical/Disability Leave.** "Extended Medical/Disability Leave" means leave without pay authorized by Personnel Board Rule 13.18(a)(1) for an Employee who has exhausted all other available forms of leave and is unable to perform the functions of his or her job.

J. **FMLA.** "FMLA" means the Family and Medical Leave Act of 1993, as amended, 29 U.S.C. §§ 2601–2654, and applicable regulations issued thereunder.

K. **FMLA Leave.** "FMLA Leave" means leave without pay available to an Employee pursuant to the FMLA.

L. **Foster Care.** "Foster Care" means 24-hour care for children in substitution for, and away from, their parents or guardian, with the placement for such 24-hour care having been made by or with the agreement of the State as a result of a voluntary agreement between the parent or guardian that the child be removed from the home, or pursuant to a judicial determination of the necessity for foster care, and involves an agreement between the State and foster family that the foster family will take care of the child. Although foster care may be with relatives of the child, State action is involved in the removal of the child from parental custody.

M. **Granted Leave Without Pay.** "Granted Leave Without Pay" means leave without pay available to a Probationary Employee, up to 48 hours, with approval by the Employee's department head, subject to the final approval of the Director of Human Resources. "Granted Leave Without Pay" also means leave without pay available to a Permanent Employee without sufficient Vacation Time who misses work due to inclement weather pursuant to the Jefferson County Inclement Weather Policy as described in the February 29, 1996 Resolution.

N. **Group Health Plan.** "Group Health Plan" means, for FMLA Leave purposes, a plan as defined by the Internal Revenue Code of 1986 at 26 U.S.C. § 5000(b)(1), which for the purposes of this Administrative Order is a Jefferson County Employee benefit plan

(including a self-insured plan) that provides health care (directly or otherwise) to Employees, former Employees, and/or the families of Employees or former Employees.

O. Health Care Provider. "Health Care Provider" means, for FMLA purposes, a doctor of medicine or osteopathy who is authorized to practice medicine or surgery (as appropriate) by the State in which he or she practices or any other person who is a Health Care Provider under the FMLA.

P. Hour. "Hour" means an hour worked by an Employee within the meaning of the Fair Labor Standards Act, and, in the case of a Salaried Employee, hours worked without regard to the Fair Labor Standards Act.

Q. Intermittent Leave. "Intermittent Leave" means FMLA Leave taken in separate periods of time due to a single illness or injury, rather than for one continuous period.

R. Key Employee. "Key Employee" means a Salaried Employee who is among the highest paid 10 percent of all Employees within 75 miles of the Salaried Employee's worksite, and no more than 10 percent of the Employees within 75 miles of the worksite may be Key Employees. To determine which Salaried Employees are Key Employees, year-to-date Employee earnings are divided by weeks worked (including weeks in which paid leave was taken), with earnings to include wages and premium pay. The determination of whether a Salaried Employee is a Key Employee shall be made at the time the Salaried Employee gives notice of the need for leave.

S. Military Leave. "Military Leave" means leave with or without pay available to an Employee pursuant to Personnel Board Rules 13.13 and 13.14.

T. **Paid Injury Leave.** "Paid Injury Leave" means leave with pay available to an Employee pursuant to Personnel Board Rule 13.12.

U. **Parent.** "Parent" means, for FMLA purposes, a person who is or was the biological parent, adoptive parent, stepparent, or foster parent of an Employee (or an individual who stood in the place of a parent to an Employee) when the Employee is/was a child under 18 years old or is/was 18 years old or older and incapable of self-care because of a mental or physical disability. Pursuant to the FMLA, this term does not include parents "in law."

V. **Personnel Board Rule.** "Personnel Board Rule" means a Personnel Board of Jefferson County rule or regulation promulgated under Act 248 of the Alabama Legislature of 1945, as amended. The terms and provisions of this Administrative Order shall be applied and administered consistent with the Personnel Board Rules, and this Administrative Order shall not limit the application of the Personnel Board Rules.

W. **Personal Leave.** "Personal Leave" means leave without pay available to a Regular Employee pursuant to Personnel Board Rule 13.18(a)(3).

X. **Reduced Schedule Leave.** "Reduced Schedule Leave" means FMLA Leave that reduces an Employee's usual number of Hours per work day or Hours per work week.

Y. **Regular Employee.** "Regular Employee" means a full time Classified Employee who has completed twelve (12) months of uninterrupted full time service following an initial appointment in the classified service.

Z. **Salaried Employee.** "Salaried Employee" means an Employee who is paid "on a salary basis" as defined in Section 541 of Title 29 of the Code of Federal

Regulations, which is the United States Department of Labor regulation defining who may qualify as exempt from the minimum wage and overtime requirements of the Fair Labor Standards Act, such as executive, administrative, computer, and professional Employees.

AA. Serious Health Condition. “Serious Health Condition” means, for FMLA purposes, an illness, injury, impairment, or physical or mental condition that involves either inpatient care (*i.e.*, an overnight stay) in a hospital, hospice, or residential medical-care facility, including any period of incapacity (*i.e.*, inability to work, attend school, or perform other regular daily activities) or subsequent treatment in connection with such inpatient care; or continuing treatment by a health care provider, which includes:

1. A period of incapacity lasting more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition that **also** includes:
 - a) treatment two or more times by or under the supervision of a health care provider (*i.e.*, in-person visits, the first within 7 days and both within 30 days of the first day of incapacity); **or**
 - b) one treatment by a health care provider (*i.e.*, an in-person visit within 7 days of the first day of incapacity) with a continuing regimen of treatment (*e.g.*, prescription medication, physical therapy); **or**
2. Any period of incapacity related to pregnancy or for prenatal care; **or**

3. Any period of incapacity or treatment for a chronic serious health condition which continues over an extended period of time, requires periodic visits (at least twice a year) to a health care provider, and may involve occasional episodes of incapacity; **or**

4. A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective; **or**

5. Any absences to receive multiple treatments for restorative surgery or for a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if not treated.

AB. Sick Leave. "Sick Leave" means leave with pay available to an Employee pursuant to Personnel Board Rule 13.10.

AC. Spouse. "Spouse" means the statutory or common law husband or wife of an Employee.

AD. Unclassified Employee. "Unclassified Employee" means a person who performs duties for which there is no defined Class in the Classified Service and as such, is exempt from the Service under §2 of the Enabling Act.

AE. Unpaid Leave. "Unpaid Leave" means and includes Administrative Leave Without Pay, Career Development Leave, Extended Medical/Disability Leave, FMLA Leave, Granted Leave Without Pay (GLWOP), Military Leave, or Personal Leave; provided, however, that Military Leave shall be paid leave to the extent required under Paragraph X, herein.

AF. Vacation Leave. "Vacation Leave" means leave with pay available to an Employee pursuant to Personnel Board Rule 13.9.

AG. Vacation Leave Bank Leave. "Vacation Leave Bank Leave" means paid Vacation Leave awarded to an Employee pursuant to the Vacation Leave Bank Plan established by Jefferson County Administrative Order 99-1, as amended.

IV. ADMINISTRATION

A. Approval of Unpaid Leave by Director. All Unpaid Leave applications shall be submitted to and approved by the Director.

B. Administration. The Director is hereby authorized to take such actions as are necessary to implement and administer this Administrative Order, and such actions shall include, but not be limited to, establishing necessary administrative rules and procedures, providing materials to Employees, requiring the use of written application forms and materials by Employees, and coordinating Unpaid Leave with Jefferson County Department Heads and the Payroll Department and the General Retirement System for Employees of Jefferson County. All such actions taken by the Director shall be consistent with the terms, provisions and requirements of this Administrative Order and in compliance with all applicable laws and regulations, including the FMLA and Personnel Board Rules.

C. Administrative Order Not a Contract of Employment. This Administrative Order is not intended to and does not create a contract of employment with any Employee and/or any vested right(s) for any Employee.

V. FAMILY AND MEDICAL LEAVE

FMLA Leave shall be governed by the following terms and provisions:

A. **Eligibility for FMLA Leave.** An Employee may become eligible to take up to 12 weeks of FMLA Leave during any 12-month period, with the 12-month period to be measured backward from the date the Employee uses any FMLA Leave (a “rolling 12-month period”). For an Employee to be eligible to take FMLA Leave, the Director must determine that the Employee has satisfied each of the following five (5) requirements:

1. **Covered Worksite.** The Employee works at a location where at least 50 Employees are employed by Jefferson County within 75 miles.

2. **Twelve Months of Employment.** The Employee must have been employed by Jefferson County for at least 12 months in total.

3. **1,250 Work Hours.** The Employee must have worked at least 1,250 hours during the 12-month period immediately preceding the commencement date of any FMLA Leave.

4. **Basic Qualifying Circumstances.** The Employee requests FMLA Leave due to one or more of the following circumstances: (i) the birth of a Child and to care for the newborn Child; (ii) the placement of a Child with an Employee for adoption or foster care and to care for the newly placed Child; (iii) to care for the Employee’s Spouse, Child, or Parent who has a Serious Health Condition; and (iv) when the Employee has a Serious Health Condition that makes the Employee unable to perform the functions of the job. A husband and wife who are both Employees and who are both eligible for FMLA Leave may be limited to a combined total of 12 weeks of leave during any 12-month period if the leave is taken for birth of the Employee's son or daughter or to care for the child after birth, for placement of a son or daughter with the Employee for adoption or foster care or to care for

the child after placement, or to care for the Employee's parent with a serious health condition.

5. **Military Family Leave Entitlements.** Eligible Employees with a spouse, son, daughter, or parent on covered active duty or call to covered active duty status in the Armed Forces in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible Employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list, for a serious injury or illness; or a veteran who is undergoing medical treatment, recuperation, or therapy, for a serious injury or illness and who was a member of the Armed Forces, including a member of the National Guard or Reserves, at any time during the period of five years preceding the date on which the veteran undergoes that medical treatment, recuperation, or therapy.

6. **Accrued FMLA Leave.** The Employee must not have previously exhausted his or her FMLA Leave entitlement.

B. **Intermittent Leave and Reduced Schedule Leave.** With respect to the

medical treatment of or recovery from a Serious Health Condition of an Employee, Spouse, Child, Parent, or of a covered servicemember's serious injury or illness, Intermittent Leave or Reduced Schedule Leave may be approved if medically necessary. Intermittent Leave or Reduced Scheduled Leave is not available for care for a newborn or newly placed Child. In the case of Intermittent Leave or Reduced Schedule Leave, the Director shall limit FMLA Leave increments to the shortest period of time that Jefferson County's payroll system uses to account for absences or use of leave, provided it is one Hour or less. To determine the amount of the salary reduction for a Salaried Employee who takes Intermittent Leave or Reduced Schedule Leave, (i) a pay rate per Hour will be determined by dividing year-to-date earnings (including wages and premium pay) by year-to-date Hours and (ii) multiplying such rate by the number of hours of Intermittent Leave or Reduced Schedule Leave taken.

Employees on Intermittent Leave are required to comply with Jefferson County's usual and customary call-in procedures for reporting absences. If you are unable to report to work or will be arriving to work late for an FMLA-related reason, you should contact your supervisor as quickly as possible, but no less than thirty (30) minutes before your regularly scheduled start time. Department call-in procedures must be followed where the department requires more advanced notice for reporting absences. Per the Federal Regulations, it is the Employee's responsibility to make every reasonable effort to arrange any planned medical treatments so as not to unduly disrupt Jefferson County's operation.

C. Application for Foreseeable FMLA Leave. It is preferred that an Employee submit a written application for FMLA Leave to the Director. An Employee must provide at least 30 days advance notice, prior to the date an FMLA Leave period is to begin, to the Director of the need for FMLA Leave that is foreseeable (such as a need based on the

expected birth of a Child, placement of a Child for adoption or foster care, or planned medical treatment for a Serious Health Condition of the Employee, a Spouse, a Child or a Parent). If an Employee fails to give 30 days advance notice for foreseeable FMLA Leave with no reasonable excuse for the delay, the Director may delay the approval of FMLA Leave until at least 30 days after the date the Employee provides notice to the Director of the need for FMLA Leave. If 30 days notice is not practical, however, such as because of a lack of knowledge of when the FMLA Leave will need to begin, a change of circumstances, or a medical emergency, notice must be given to the Director as soon as practicable.

D. Application for Unforeseeable FMLA Leave. When the approximate timing of the need for FMLA Leave is not foreseeable, an Employee must give notice to the Director as soon as practicable. It should be practicable for the Employee to provide notice of the need for leave either the same day or the next business day that the need for FMLA Leave becomes known to the Employee. Notice may be given by the Employee's spokesperson (e.g., spouse, adult family member, or other responsible party) if the Employee is unable to do so personally.

If the Employee is out for at least three consecutive, full calendar days for possible reasons that might relate to sick leave, the Employee's department will notify Human Resources of the absence and Human Resources will send Family Medical Leave Act (FMLA) paperwork to the Employee. In instances of Injury With Pay (IWP), the Occupational Health Nurse will notify Human Resources. The Director will delay or deny FMLA Leave if the Employee fails to comply with notice requirements.

E. Decision on Application. When applying to the Director for FMLA Leave or giving notice to the Director of the need for FMLA Leave, an Employee must provide sufficient information for the Director to be able to determine whether the requested leave is FMLA qualifying. Failure to provide such information may result in the denial of FMLA protection.

1. Eligibility Determination. Upon receipt of an application (or notification of a need) for FMLA Leave, the Director will initially determine whether the Employee is eligible to take FMLA leave and so notify the Employee and Department Head and Payroll Manager within five business days of the Employee's request for leave or when Jefferson County acquires sufficient knowledge of an FMLA qualifying event, absent exigent circumstances.

2. FMLA Leave Determination and Designation. If the Employee is eligible to take FMLA Leave, the Director may require the Employee to provide certification(s) that will be considered by the Director in deciding whether the requested leave is FMLA qualifying. If the Employee fails to timely provide the requested certification(s) and/or sufficient information, the Director may delay approval or deny the request for FMLA Leave. Upon timely receipt of the requisite information from the Employee, the Director shall determine whether the requested leave is FMLA qualifying, designate whether the requested leave is (or is not) FMLA qualifying, and give written notice of such determination and designation to the Employee and his or her Department Head and the Payroll Manager within five business days.

3. **Timing of Designation.** An Employee and his or her Department Head and the Payroll Manager shall, where possible, be informed by the Director, prior to the commencement of any leave or before the conclusion of any leave, whether the leave will be approved and designated as FMLA Leave.

4. **Transfer to Alternative Position.** The Director may require an Employee who has requested foreseeable Intermittent Leave or Reduced Schedule Leave due to planned medical treatment to transfer temporarily to a vacant alternative position provided that (i) the Employee is qualified for such alternative position; (ii) the alternative position has pay and benefits equivalent to those of the Employee's regular position; and (iii) the alternative position better accommodates recurring periods of FMLA Leave than the Employee's regular position.

E. **Leave Substitution and Concurrent Leave.** The Director shall require the Employee to substitute all paid Sick Leave and/or Vacation Leave for FMLA Leave to the fullest extent that the FMLA allows such substitution. When an Employee has begun taking Sick Leave and/or Vacation Leave and the Director thereafter learns that the Sick Leave and/or Vacation Leave is being taken for an FMLA qualifying reason, the Director shall count such Sick Leave and/or Vacation Leave as FMLA Leave. The Director shall also require that certain periods of workers' compensation absence or Paid Injury Leave or Vacation Leave Bank Leave run concurrently with FMLA Leave to the fullest extent permitted by the FMLA.

1. **Order of Substitution and Counting.** When paid Sick Leave and/or paid Vacation Leave are substituted for FMLA Leave, paid Sick Leave shall first be substituted. After all paid Sick Leave is exhausted, then all paid Vacation Leave shall be

substituted. The substituted Sick Leave and/or Vacation Leave shall be counted against the Employee's FMLA Leave entitlement.

2. **Workers' Compensation, Paid Injury Leave and Vacation Leave**

Bank. When an Employee is on a workers' compensation absence and/or is absent on Paid Injury Leave or Vacation Leave Bank Leave due to a Serious Health Condition, the Director shall designate the Employee's FMLA Leave entitlement to run concurrently with the workers' compensation absence and/or Paid Injury Leave and/or Vacation Leave Bank Leave, and the period of the workers' compensation absence and/or Paid Injury Leave and/or Vacation Leave Bank Leave shall count against the Employee's FMLA Leave entitlement to the fullest extent permitted by the FMLA.

3. **Designation Before or After a Paid Leave or Absence Begins.** It is

the intent of this Administrative Order that paid Sick Leave, Vacation Leave, Paid Injury Leave, Vacation Leave Bank Leave and periods of workers' compensation absence run concurrent with and count towards an Employee's FMLA Leave entitlement as designated by the Director and to the fullest extent permitted by the FMLA. If the Director has insufficient information to make such a designation before such paid leave commences, the Director (i) may make the designation after the paid leave commences and (ii) will notify the Employee and the Employee's Department Head and Payroll Manager of any such designation.

F. **Required Certification.** When FMLA Leave is requested to care for a Spouse, Child or Parent who has a Serious Health Condition or due to the Employee's own Serious Health Condition, the Director may notify the Employee that a written medical certification issued by a Health Care Provider must be provided to the Director and shall

notify the Employee of the consequences of failing to provide the medical certification. When an Employee is the legal guardian of an adult ward, the Director may require that the Employee's leave be supported by legal guardianship documentation. The Director may also require that an Employee's leave because of a qualifying exigency or to care for a covered servicemember with a serious injury or illness be supported by a certification. All medical information, including certifications, recertifications, or medical histories of Employees or their family members, obtained in connection with FMLA leave, will be maintained by Human Resources in confidential FMLA files. Said documents should be delivered to Human Resources by the Employee, the Employee's Health Care Provider, or the Employee's designee. The Director also may require additional certification(s) after FMLA Leave begins to the fullest extent allowed by the FMLA. If the Employee does not supply the requested certification, leave taken by the Employee may not be FMLA qualifying. The Director will advise an Employee whenever a certification is incomplete and/or insufficient and provide the Employee a reasonable opportunity to cure any such deficiency. It is the Employee's responsibility to cure such deficiency within the seven (7) calendar day period after the date the Employee is notified of the deficiency by the Director. Failure to provide the appropriate documentation or cure the deficiency within 7 calendar days could result in a delay in the commencement of the leave (if not already taken); or a withdrawal of any preliminary designation of FMLA Leave, in which case the Employee's leave may be unauthorized, subjecting the Employee to discipline up to and including discharge for an unapproved absence.

1. **Additional Medical Opinions.** At the discretion of the Director, the Employee may be required to obtain the opinion of a second Health Care Provider designated by the Director. Jefferson County will pay for any such second opinion. In the event of a conflict between the first and second medical opinions, the Director may, at Jefferson County's expense, obtain a third opinion from a Health Care Provider approved jointly by the Director and the Employee. This third opinion shall be final and binding.

2. **Return to Work.** The Director may require an Employee on FMLA Leave to report periodically on his or her status and intention to return to work. The Director also may require medical certification and/or fitness-for-duty certification that an Employee is able to resume work as a condition of job restoration and/or that an Employee is unable to return to work after expiration of FMLA Leave due to a Serious Health Condition.

G. **Accounting for FMLA Leave.** When an Employee requests FMLA Leave, the Director shall permanently maintain a file relating to the request which shall contain written documentation evidencing how the Employee requested FMLA Leave (by written application, phone, fax, letter, etc.), the date the Employee requested the FMLA Leave, the duration of the FMLA Leave requested by the Employee, and the need for FMLA Leave as stated by the Employee. The file shall also contain a log or tracking sheet the Director shall use to track the FMLA Leave used by the Employee, to calculate the amount of FMLA Leave taken by the Employee, and to determine the amount of the Employee's remaining eligibility for FMLA Leave. The file shall also contain all application forms and written materials relating to the Employee and FMLA Leave. No FMLA medical certification or copies thereof

should be kept in files maintained by the Employee's Department Head, supervisor, or payroll coordinator.

H. Job Reinstatement and Employee Benefits. The Director shall apply Sections 825.209 through 825.219 of Title 29 of the United States Code of Federal Regulations in facilitating or denying job reinstatement and in administering Jefferson County Employee benefit plans and programs.

1. Reinstatement. On return from approved FMLA Leave, an Employee is entitled to be returned to the same position held when the FMLA Leave began, or to an equivalent position with equivalent benefits, pay and other terms and conditions of employment. Jefferson County's obligation under the FMLA to restore an Employee to the same or equivalent employment ceases if and when the employment relationship would have terminated if the Employee had not taken FMLA Leave, such as when the Employee informs Jefferson County of his or her intent not to return from the FMLA Leave, fails to return from FMLA Leave, or continues on leave after exhausting his or her FMLA Leave entitlement. If the Director, in consultation with a Key Employee's Department Head and the Jefferson County Attorney, determines that restoration of the Key Employee to employment will cause substantial and grievous economic injury to the operations of Jefferson County, job restoration under the FMLA (including, without limitation, Sections 825.216 through 825.219 of the Code of Federal Regulations) may be denied to the Key Employee.

2. Group Health Plan Coverage. During any FMLA Leave, an Employee's Group Health Plan coverage will be maintained, but only on the same conditions as such coverage would have been provided if the Employee had been continuously

employed during his or her entire FMLA Leave period. Therefore, any share of Group Health Plan premiums which had been paid by the Employee prior to the FMLA Leave must continue to be paid by the Employee during the FMLA Leave period. The Director may require that the Employee's share of Group Health Plan premiums during the FMLA Leave period be paid in any of the following ways: (i) payment would be due at the same time as it would be made if by payroll deduction; (ii) payment would be due on the same schedule as payments are made for continuation of coverage following a qualifying event under the Public Health Service Act, as amended by the Consolidated Omnibus Budget Reconciliation Act (COBRA); (iii) payment would be prepaid pursuant to a cafeteria plan at the Employee's option; (iv) existing rules, if any, for payment by Employees on "leave without pay" would be followed, provided that such rules do not require prepayment (i.e., prior to the commencement of the leave) of the premiums that will become due during a period of FMLA Leave or payment of higher premiums than if the Employee had continued to work instead of taking FMLA Leave; or (v) another system voluntarily agreed to between the Director and the Employee, which may include prepayment of premiums (e.g., through increased payroll deductions when the need for the FMLA Leave is foreseeable). An Employee who is receiving payments as a result of a workers' compensation injury must make arrangements with the Director for payment of Group Health Plan benefits when simultaneously taking FMLA Leave. Subject to Section 825.212 of Title 29 of the United States Code of Federal Regulations, Jefferson County's obligation to maintain Group Health Plan coverage under FMLA ceases if an Employee's premium payment is more than 30 days late. An Employee may choose not to retain Group Health Plan coverage during FMLA Leave. Except as otherwise provided by the FMLA for Key Employees, Jefferson County's obligation to

maintain Group Health Plan coverage during FMLA Leave ceases if and when the employment relationship would have terminated if the Employee had not taken FMLA Leave, such as when the Employee informs Jefferson County of his or her intent not to return from the FMLA Leave, fails to return from FMLA Leave, or continues on leave after exhausting his or her FMLA Leave entitlement. Subject to Section 825.213 of Title 29 of the United States Code of Federal Regulations, Jefferson County may recover from an Employee its share of Group Health Plan premiums for a period of FMLA Leave if the Employee fails to return to work after his or her FMLA Leave entitlement has been exhausted or expires.

3. **Other Employee Benefits.** An Employee's entitlement to benefits (other than Group Health Plan benefits) is determined under the applicable Jefferson County policy(ies) for providing such benefits when the Employee is on other forms of leave (paid or unpaid, as appropriate).

VI. ADMINISTRATIVE LEAVE WITHOUT PAY

An Employee may be placed on Administrative Leave Without Pay for a period of up to 365 days for reason(s) deemed to be in the best interest of Jefferson County. Only the Director may place an Employee on Administrative Leave Without Pay. The Director shall consult with the Employee's Department Head and the Jefferson County Attorney in deciding whether to place the Employee on Administrative Leave Without Pay. A Regular Employee who is involuntarily placed on Administrative Leave Without Pay for a period exceeding five (5) working days may appeal to the Personnel Board pursuant to Personnel Board Rule 13.20(c).

If an Employee is enrolled in and covered by Jefferson County group insurance plans, policies or arrangements before commencing a period of Administrative Leave, the Director will make available the continuation of such coverage during the period of the Administrative Leave to the extent permitted under such group insurance plans, policies and arrangements. Any continuation of coverage under a Jefferson County group insurance plan, policy or arrangement during a period of Administrative Leave shall be contingent upon an Employee making arrangements with the Director to continue to make any premium contributions for which the Employee is responsible and then timely paying such premium contributions. Following the termination of a period of Administrative Leave, job reinstatement shall be provided in accordance with Personnel Board Rules.

VII. CAREER DEVELOPMENT LEAVE

An Employee who desires to engage in a course of study that will materially contribute to the value of his or her Jefferson County service may be granted a period of Career Development Leave not to exceed 365 days. Only the Director may approve Career Development Leave. To apply for Career Development Leave, an Employee must complete a written application form specified by the Director and deliver the form along with materials explaining and evidencing the course of study to his/her Department Head for consideration. The Department Head will recommend approval or denial of the request and forward a copy of the request to Human Resources, accompanied by a memo addressed to the Director detailing how the Employee's duties will be covered during the absence, if approved. The memo should state that no overtime or temporary agency personnel will be utilized to cover the Employee's duties. The memo should also detail the rationale for the recommendation to approve/deny the request. If the Department Head has appointed a designee to

approve/disapprove requests and prepare the memo, the Department Head is also required to submit a memo to the Director naming the designee. The Director shall consult with the requesting Employee's Department Head and the Jefferson County Attorney in deciding whether to grant the application for Career Development Leave.

If an Employee is enrolled in and covered by Jefferson County group insurance plans, policies or arrangements before commencing a period of Career Development Leave, the Director will make available the continuation of such coverage during the period of the Career Development Leave to the extent permitted under such group insurance plans, policies and arrangements. Any continuation of coverage under a Jefferson County group insurance plan, policy or arrangement during a period of Career Development Leave shall be contingent upon an Employee making arrangements with the Director to continue to make any premium contributions for which the Employee is responsible and then timely paying such premium contributions. Following the termination of a period of Career Development Leave, job reinstatement shall be provided in accordance with Personnel Board Rules.

VIII. EXTENDED MEDICAL/DISABILITY LEAVE

An Employee who is unable to perform the functions of the Employee's position and has exhausted all Unpaid Leave and all Paid Injury Leave, Sick Leave, Vacation Leave, or other leave with pay may be granted a period of Extended Medical/Disability Leave not to exceed 365 days. Only the Director may approve Extended Medical/Disability Leave. The Director shall consult with a requesting Employee's Department Head and the Jefferson County Attorney in deciding whether to grant the Employee's application for Extended Medical/Disability Leave.

A. Application. To apply for Extended Medical/Disability Leave, the Employee must complete a written application form specified by the Director and deliver to his/her Department Head for consideration. The Department Head will recommend approval or denial of the request and forward a copy of the request to Human Resources, accompanied by a memo detailing how the Employee's duties will be covered during the absence, if approved. The memo should state that no overtime or temporary agency personnel will be utilized to cover the Employee's duties. The memo should also detail the rationale for the recommendation to approve/deny the request. If the Department Head has appointed a designee to approve/disapprove requests and prepare the memo, the Department Head is also required to submit a memo to the Director naming the designee. In addition to the completed application, the Employee must also provide to the Director a written certificate signed by a licensed physician that provides (i) a general explanation of the Employee's condition, (ii) a certification that the Employee is unable to perform the functions of the Employee's position, and (iii) the probable duration of the Employee's incapacitation.

B. Return to Work. If during a period of Extended Medical/Disability Leave the Employee becomes capable of performing the functions of the Employee's position, the Employee shall so notify the Director. When the Employee provides such notice, the Employee shall also provide the Director with a written certification from a licensed physician that the Employee is able to perform the functions of the Employee's position.

C. Reinstatement. If an Employee is enrolled in and covered by Jefferson County group insurance plans, policies or arrangements before commencing a period of Extended Medical/Disability Leave, the Director will make available the continuation of such

coverage during the period of the Extended Medical/Disability Leave to the extent permitted under such group insurance plans, policies and arrangements. Any continuation of coverage under a Jefferson County group insurance plan, policy or arrangement during a period of Extended Medical/Disability Leave shall be contingent upon an Employee making arrangements with the Director to continue to make any premium contributions for which the Employee is responsible and then timely paying such premium contributions. Following the termination of a period of Extended Medical/Disability Leave, job reinstatement shall be provided in accordance with Personnel Board Rules.

IX. GRANTED LEAVE WITHOUT PAY

Probationary Employees who are absent from work without eligibility for vacation or sick leave shall be eligible for up to 48 hours of granted leave without pay (GLWOP). The Employee must submit a properly executed Request for Authorized Leave (Excluding FMLA) form through the chain of command to the Human Resources Department before commencement of the absence. Requests for GLWOP must be submitted by the end of the pay period that the absence occurred.

Any Employee who misses work time due to inclement weather conditions shall have the missed work time charged to Granted Leave Without pay (GLWOP) if sufficient vacation leave is not available.

X. MILITARY LEAVE

The Jefferson County Commission supports the United States Armed Forces and will comply with applicable provisions of the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), Sections 31-2-13 and 31-12-6 of the Code of Alabama, the Jefferson

County Commission's January 27, 2004 Resolution (Minute Book 143, Pages 556-557) establishing the War on Terrorism Supplemental Military Benefit, and Personnel Board Rules 13.13 and 13.14. An Employee must notify the Director of his or her need for Military Leave and complete such Military Leave application forms and materials as are provided to the Employee by the Director. Employees shall be eligible for Military Leave without pay (and with pay) in accordance with USERRA, Sections 31-2-13 and 31-12-6 of the Code of Alabama, and Personnel Board Rules 13.13 and 13.14.

XI. PERSONAL LEAVE

An Employee may be granted a period of Personal Leave, not to exceed 365 days, for personal reason(s) considered sufficient by the Director. Only the Director may approve Personal Leave. To apply for Personal Leave, an Employee must complete a written application form specified by the Director and return the completed form to his/her Department Head for consideration. The Director shall consult with the requesting Employee's Department Head and the Jefferson County Attorney in deciding whether to grant the application for Personal Leave.

The Department Head will recommend approval or denial of the request and forward a copy of the request to Human Resources, accompanied by a memo detailing how the Employee's duties will be covered during the absence, if approved. The memo should state that no overtime or temporary agency personnel will be utilized to cover the Employee's duties. The memo should also detail the rationale for the recommendation to approve/deny the request. If the Department Head has appointed a designee to approve/disapprove requests and prepare the memo, the Department Head is also required to submit a memo to the Director naming the designee.

If an Employee is enrolled in and covered by Jefferson County group insurance plans, policies or arrangements before commencing a period of Personal Leave, the Director will make available the continuation of such coverage during the period of the Personal Leave to the extent permitted under such group insurance plans, policies and arrangements.

Any continuation of coverage under a Jefferson County group insurance plan, policy or arrangement during a period of Personal Leave shall be contingent upon an Employee making arrangements with the Director to continue to make any premium contributions for which the Employee is responsible and then timely paying such premium contributions. Following the termination of a period of Personal Leave, job reinstatement shall be provided in accordance with Personnel Board Rules.

XII. EMPLOYEE DISCIPLINE

Employees who are AWOL and/or have abused Unpaid Leave may be disciplined as provided by Personnel Board Rules 12 and 13.6 and Jefferson County Administrative Order 02-5, as amended. Any Employee who fraudulently seeks or obtains FMLA Leave is not protected by FMLA's job restoration or maintenance of health benefits provisions and will be subject to disciplinary action, including termination.

XIII. EFFECTIVE DATE

This amended Administrative Order shall be effective at 12:01 a.m., on _____ 2011.

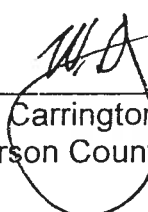
DONE and ORDERED at the Jefferson County Courthouse, this 14 day of Dec, 2010

APPROVED BY THE
JEFFERSON COUNTY COMMISSION

DATE: 12-14-10

MINUTE BOOK: 161

PAGE(S): 71-79



W.D. Carrington, President
Jefferson County Commission

SAMPLE



Jefferson County Commission

Family Medical Leave Packet – Family Member’s Serious Health Condition

Please find enclosed unpaid leave forms you must complete or have your health care provider (doctor, dentist, etc.) complete and return to the Human Resources Department. Below are itemized instructions for each enclosed form. It is important that you follow the instructions and submit completed forms in a timely manner. Incomplete forms will delay the processing of your request.

1. **Employee Request for Family and Medical Leave** – You must complete this form and submit it to Human Resources.
2. **Certification of Health Care Provider for Family Member’s Serious Health Condition (Family and Medical Leave Act)** – You must complete Section II of this form first. After addressing Section II, give the form to your family member’s health care provider to complete the remainder of the certification (medical). **You are responsible for returning this document to the HR Department as quickly as possible, but not later than 15 calendar days from the date of this letter. Failure to provide the appropriate documentation within 15 calendar days could result in a delay in the commencement of the leave (if not already taken); or a withdrawal of any preliminary designation of FMLA Leave, in which case your leave may be unauthorized, subjecting you to discipline up to and including discharge for an unapproved absence.** Documents may be submitted by FAX to (205) 325-8793.
3. **Authorization to Health Care Provider to Release Medical Documentation** – You must complete Section A of this form and give it to your family member’s health care provider at the same time you give him/her the Certification of Health Care Provider for Family Member’s Serious Health Condition form.
4. **Benefit Payment Election While on Approved Unpaid Leave** – You must complete this form and return it to HR when you submit the Employee Request for Family and Medical Leave form. Should you have questions regarding payment of benefits, please contact Nakia Buckner at 325-5249.
5. **Family and Medical Leave Family Member Form** – For the purpose of confirming family relationships under the Family and Medical Leave Act (FMLA), in accordance with 29 CFR §825.113(d) you are requested to list the name, relationship to you, and address of each of your living parents, sons, daughters, and spouse.

Should you have questions, please contact Bettie Banks-Coleman at 325-5249.

Regards,

SAMPLE
Bettie Banks-Coleman
Personnel Analyst

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.



For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV



U.S. Wage and Hour Division

SAMPLE

JEFFERSON COUNTY COMMISSION
EMPLOYEE REQUEST FOR FAMILY AND MEDICAL LEAVE
(May be paid or unpaid)



Part A. Employee Information

Employee's Name: SAMPLE Department: _____
(L) (First) (MI)
Current Address: _____
Work Phone: _____ Home Phone: _____ Cell Phone: _____
Job Title: _____ Hire Date: _____
Employee Appointment Status: _____

Part B. Leave Dates (Continuous or Intermittent)

Estimated Leave Start Date: _____ Estimated Date of Return: _____
 Leave is requested on an intermittent or reduced leave schedule. Indicate the days of the week and/or hours during the day you will be absent: _____

Part C. Reason for Leave

- Leave is for my own serious health condition.
- Leave is for the birth of a child or placement of a child for adoption or foster care. Indicate the expected date of birth or placement.
_____ (Date) Spouse is employed by the Jefferson County Commission: YES NO
- Leave is to care for a family member with a serious health condition. Specify the name and relationship of the family member:
_____ (Name) _____ (Relationship to You)
- Leave is for a qualifying exigency arising out of the fact that your spouse/ child/ parent is on active duty status in support of a contingency operation as a member of the National Guard or Reserves.
_____ (Name) _____ (Relationship to You)
- Leave is to care for a spouse/ child/ parent/ next of kin who is a covered military service member with a serious injury or illness.
_____ (Name) _____ (Relationship to You)
- Required medical certification form is attached.
- Documentation to establish required relationship between my family member and me (if applicable) is attached.

SAMPLE

(Signature of Employee or Designee)

(Date)

(If employee is not available to sign request, note verbal conversation above. Include date of the conversation and the signature of the person who completed the form.)

SAMPLE

Certification of Health Care Provider for
Family Member's Serious Health Condition
(Family and Medical Leave Act)

Jefferson County Commission
Human Resources Department
Compliance Division



SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: SAMPLE
First Middle Last

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

SAMPLE

Employee Signature

Date

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (_____) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
___ No ___ Yes. If so, dates of admission: _____

Date(s) you treated the patient for condition: _____

Was medication, other than over-the-counter medication, prescribed? ___ No ___ Yes.

Will the patient need to have treatment visits at least twice per year due to the condition? ___ No ___ Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
___ No ___ Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? ___ No ___ Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

SAMPLE

SAMPLE

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? No Yes.

Estimate the beginning and ending dates for the period of incapacity: _____

During this time, will the patient need care? No Yes

Explain the care needed by the patient and why such care is medically necessary:

5. Will the patient require follow-up treatments, including any time for recovery? No Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Explain the care needed by the patient, and why such care is medically necessary: _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? No Yes

Estimate the hours the patient needs care on an intermittent basis, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

Explain the care needed by the patient, and why such care is medically necessary:

SAMPLE

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ___ No ___ Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: ___ times per ___ week(s) ___ month(s)

Duration: ___ hours or ___ day(s) per episode

Does the patient need care during these flare-ups? ___ No ___ Yes.

Explain the care needed by the patient, and why such care is medically necessary: _____

SAMPLE

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

SAMPLE

Signature of Health Care Provider

Date

SAMPLE



JEFFERSON COUNTY COMMISSION
AUTHORIZATION TO HEALTH CARE PROVIDER TO RELEASE MEDICAL
DOCUMENTATION IN SUPPORT OF EMPLOYEE'S REQUEST FOR LEAVE OF ABSENCE

Section A (to be completed by Employee)

Name SAMPLE Job Title

Department Division

Reason for Leave

I AUTHORIZE TO RELEASE THE NECESSARY
INFORMATION DETAILED ON THE ATTACHED FORM (JEFFERSON COUNTY COMMISSION FAMILY AND MEDICAL
LEAVE ACT MEDICAL CERTIFICATION FORM) TO THE HUMAN RESOURCES DEPARTMENT OF THE JEFFERSON
COUNTY COMMISSION IN SUPPORT OF MY REQUEST FOR A MEDICAL LEAVE OF ABSENCE.

SAMPLE
Employee Signature

/ /
Date

Section B (to be completed by the Health Care Provider)

INSTRUCTION TO HEALTH CARE PROFESSIONAL: The above-named employee has requested a leave of absence from
his/her regular duties due to medical reasons. As this employee's physician, dentist, or other health care provider, we ask that
you verify the necessity of this request. Please complete the attached certification (Jefferson County Commission Family and
Medical Leave Act Medical Certification). It is not necessary to provide diagnosis information.

Health Care Provider

Please Complete Attached Medical Certification

SAMPLE



JEFFERSON COUNTY COMMISSION
BENEFIT PAYMENT ELECTION WHILE ON APPROVED (UNPAID) LEAVE

Form to be completed by Employee and returned to Human Resources with the FMLA Request

Name Department

Current Address Street Address City State Zip Code

Work Phone Home Phone Cell Phone

To continue your current benefits, you must pay your portion of insurance premiums. You can find the amount you owe for insurance coverage monthly on your last two pay stubs. Please indicate the amount you pay per month for insurance below:

Health Insurance, Dental Insurance, Vision Insurance, Voluntary Life, Voluntary Accident, Total Amount

Please make your cashier's check or money order (not personal check) payable to Jefferson County Treasurer and return it with your leave request, or mail the check to the Human Resources Department at:

Jefferson County Human Resources Department
Room A610 - Courthouse Annex
716 Richard Arrington, Jr. Blvd. N.
Birmingham, AL 35203

I have read this information and I understand that the Jefferson County Commission is not responsible for payment of premium of medical / dental / vision insurance or other benefit premiums (i.e., voluntary group term life insurance, voluntary accident insurance) during my approved leave of absence. However, Jefferson County will continue to pay its portion of premiums. Thus, I agree to the following:

- That if I elect to continue coverage under these plans, I will be solely responsible for the payment of my portion of the premiums for such plans.
That if I fail to pay any required premium, my coverage under that plan will end effective the last day of the month for which a premium has been paid.
That if I do not elect to continue my benefits by paying premiums or by failing to pay premiums on time during my approved leave of absence, my eligibility for benefits may be lost.

Employee Signature SAMPLE

Date

SAMPLE



JEFFERSON COUNTY COMMISSION
FAMILY AND MEDICAL LEAVE - FAMILY MEMBER FORM

For the purpose of confirming family relationships under the Family and Medical Leave Act (FMLA), in accordance with 29 CFR §825.113(d) you are requested to list the name, relationship to you, and address of each of your living parents, sons, daughters, and spouse. For the purposes of this form:

- a. The term "parent" means, for FMLA purposes, a person who is or was the biological parent, adoptive parent, stepparent, or foster parent of an employee. This term does not include parents "in law."
b. The term "son or daughter" means, for FMLA purposes, any person who is under 18 years old or any person 18 years old or older who is incapable of self-care because of a mental or physical disability whose relationship to an employee is that of (i) a biological, adopted, or foster child, (ii) a stepchild, (iii) a legal ward or (iv) a child of a person standing in the place of a parent.
c. The term "spouse" means the statutory or common law husband or wife of an employee.

Please report any future changes regarding the information contained in this form to the Jefferson County Commission Human Resources Department. If additional space is needed, please use the back of this form.

Relationship to Employee
(If child, please state date of birth)

Name of Family Member (print) Relationship Date of Birth Address of Family Member

1. _____
2. _____
3. _____
4. _____
5. _____

I certify that the foregoing information is correct and that I have received Jefferson County Commission Administrative Order 07-02.

SAMPLE

Print Name

Department

Signature

Date

SAMPLE



**Jefferson County Commission
Family Medical Leave Packet – Employee’s Serious Health Condition**

Please find enclosed unpaid leave forms you must complete or have your health care provider (doctor, dentist, etc.) complete and return to the Human Resources Department. Below are itemized instructions for each enclosed form. It is important that you follow the instructions and submit completed forms in a timely manner. Incomplete forms will delay the processing of your request.

1. **Employee Request for Family and Medical Leave** – You must complete this form and submit it to Human Resources.
2. **Certification of Health Care Provider for Employee’s Serious Health Condition (Family and Medical Leave Act)** – You must complete Section II of this form first. After addressing Section II, give the form to your health care provider to complete the remainder of the certification (medical). You must give your health care provider your **job description** when you give him/her this form. **You are responsible for returning this document to the HR Department as quickly as possible, but not later than 15 calendar days from the date of this letter. Failure to provide the appropriate documentation within 15 calendar days could result in a delay in the commencement of the leave (if not already taken); or a withdrawal of any preliminary designation of FMLA Leave, in which case your leave may be unauthorized, subjecting you to discipline up to and including discharge for an unapproved absence.** Documents may be submitted by FAX to (205) 325-8793.
3. **Authorization to Health Care Provider to Release Medical Documentation** – You must complete Section A of this form and give it to your health care provider at the same time you give him/her the Certification of Health Care Provider for Employee’s Serious Health Condition form.
4. **Benefit Payment Election While on Approved Unpaid Leave** – You must complete this form and return it to HR when you submit the Employee Request for Family and Medical Leave form. Should you have questions regarding payment of benefits, please contact Nakia Buckner at 325-5249.
5. **Family and Medical Leave Family Member Form** – For the purpose of confirming family relationships under the Family and Medical Leave Act (FMLA), in accordance with 29 CFR §825.113(d) you are requested to list the name, relationship to you, and address of each of your living parents, sons, daughters, and spouse.
6. **Family Medical Leave Return to Work Medical Certification** – You should hold this form until you are ready to return to work. When you are ready to return to work, complete the top of the form entitled “Instructions for the County Employee”. Then, give the form to your health care provider and he/she must complete the bottom portion of the form entitled “To the Health Care Provider.” **You may not be permitted to return to work until Human Resources receives this completed form.**

Should you have questions, please contact Bettie Banks-Coleman at 325-5249.

Regards,

SAMPLE
Bettie Banks-Coleman
Personnel Analyst

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employer's may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.



For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV



U.S. Wage and Hour Division

SAMPLE

JEFFERSON COUNTY COMMISSION
EMPLOYEE REQUEST FOR FAMILY AND MEDICAL LEAVE
(May be paid or unpaid)



Part A. Employee Information

Employee's Name: SAMPLE Department: _____
(Last) (First) (MI)
Current Address: _____
Work Phone: _____ Home Phone: _____ Cell Phone: _____
Job Title: _____ Hire Date: _____
Employee Appointment Status: _____

Part B. Leave Dates (Continuous or Intermittent)

Estimated Leave Start Date: _____ Estimated Date of Return: _____
 Leave is requested on an intermittent or reduced leave schedule. Indicate the days of the week and/or hours during the day you will be absent: _____

Part C. Reason for Leave

- Leave is for my own serious health condition.
- Leave is for the birth of a child or placement of a child for adoption or foster care. Indicate the expected date of birth or placement.
_____ Spouse is employed by the Jefferson County Commission: YES NO
(Date)
- Leave is to care for a family member with a serious health condition. Specify the name and relationship of the family member:
_____ (Name) _____ (Relationship to You)
- Leave is for a qualifying exigency arising out of the fact that your spouse/ child/ parent is on active duty status in support of a contingency operation as a member of the National Guard or Reserves.
_____ (Name) _____ (Relationship to You)
- Leave is to care for a spouse/ child/ parent/ next of kin who is a covered military service member with a serious injury or illness.
_____ (Name) _____ (Relationship to You)
- Required medical certification form is attached.
- Documentation to establish required relationship between my family member and me (if applicable) is attached.

SAMPLE
(Signature of Employee or Designee)

(Date)

(If employee is not available to sign request, note verbal conversation above. Include date of the conversation and the signature of the person who completed the form.)

SAMPLE

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

Jefferson County Commission Human Resources Department Compliance Division



SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SAMPLE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: () Fax: ()

SAMPLE

SAMPLE

PART A: MEDICAL FACTS

1. Approximate date condition commenced: SAMPLE
Probable duration of condition: _____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
 No Yes. If so, dates of admission:

Date(s) you treated the patient for condition:

Will the patient need to have treatment visits at least twice per year due to the condition? No Yes.

Was medication, other than over-the-counter medication, prescribed? No Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
 No Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? No Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: No Yes.

If so, identify the job functions the employee is unable to perform:

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

SAMPLE

SAMPLE

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___ No ___ Yes.

If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___ No ___ Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?
___ No ___ Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ___ No ___ Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?
___ No ___ Yes. If so, explain:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

SAMPLE

SAMPLE



JEFFERSON COUNTY COMMISSION
AUTHORIZATION TO HEALTH CARE PROVIDER TO RELEASE MEDICAL
DOCUMENTATION IN SUPPORT OF EMPLOYEE'S REQUEST FOR LEAVE OF ABSENCE

Section A (to be completed by Employee)

Name (Please Print) SAMPLE Job Title

Department SAMPLE Division

Reason for Leave

I AUTHORIZE TO RELEASE THE NECESSARY
INFORMATION DETAILED ON THE ATTACHED FORM (JEFFERSON COUNTY COMMISSION FAMILY AND MEDICAL
LEAVE ACT MEDICAL CERTIFICATION FORM) TO THE HUMAN RESOURCES DEPARTMENT OF THE JEFFERSON
COUNTY COMMISSION IN SUPPORT OF MY REQUEST FOR A MEDICAL LEAVE OF ABSENCE.

SAMPLE
Employee Signature

/ /
Date

Section B (to be completed by the Health Care Provider)

INSTRUCTION TO HEALTH CARE PROFESSIONAL: The above-named employee has requested a leave of absence from
his/her regular duties due to medical reasons. As this employee's physician, dentist, or other health care provider, we ask that
you verify the necessity of this request. Please complete the attached certification (Jefferson County Commission Family and
Medical Leave Act Medical Certification). It is not necessary to provide diagnosis information.

Health Care Provider

Please Complete Attached Medical Certification

SAMPLE



JEFFERSON COUNTY COMMISSION
BENEFIT PAYMENT ELECTION WHILE ON APPROVED (UNPAID) LEAVE

Form to be completed by Employee and returned to Human Resources with the FMLA Request

Name SAMPLE Department

Current Address Street Address City State Zip Code

Work Phone Home Phone Cell Phone

To continue your current benefits, you must pay your portion of insurance premiums. You can find the amount you owe for insurance coverage monthly on your last two pay stubs. Please indicate the amount you pay per month for insurance below:

\$ Health Insurance \$ Voluntary Life
\$ Dental Insurance \$ Voluntary Accident
\$ Vision Insurance \$ Total Amount

Please make your cashier's check or money order (not personal check) payable to Jefferson County Treasurer and return it with your leave request, or mail the check to the Human Resources Department at:

Jefferson County Human Resources Department
Room A610 - Courthouse Annex
716 Richard Arrington, Jr. Blvd. N.
Birmingham, AL 35203

I have read this information and I understand that the Jefferson County Commission is not responsible for payment of premium of medical / dental / vision insurance or other benefit premiums (i.e., voluntary group term life insurance, voluntary accident insurance) during my approved leave of absence. However, Jefferson County will continue to pay its portion of premiums. Thus, I agree to the following:

- That if I elect to continue coverage under these plans, I will be solely responsible for the payment of my portion of the premiums for such plans.
That if I fail to pay any required premium, my coverage under that plan will end effective the last day of the month for which a premium has been paid.
That if I do not elect to continue my benefits by paying premiums or by failing to pay premiums on time during my approved leave of absence, my eligibility for benefits may be lost.

Employee Signature SAMPLE

Date

SAMPLE



JEFFERSON COUNTY COMMISSION
FAMILY AND MEDICAL LEAVE - FAMILY MEMBER FORM

For the purpose of confirming family relationships under the Family and Medical Leave Act (FMLA), in accordance with 29 CFR §825.113(d) you are requested to list the name, relationship to you, and address of each of your living parents, sons, daughters, and spouse. For the purposes of this form:

- a. The term "parent" means, for FMLA purposes, a person who is or was the biological parent, adoptive parent, stepparent, or foster parent of an employee. This term does not include parents "in law."
b. The term "son or daughter" means, for FMLA purposes, any person who is under 18 years old or any person 18 years old or older who is incapable of self-care because of a mental or physical disability whose relationship to an employee is that of (i) a biological, adopted, or foster child, (ii) a stepchild, (iii) a legal ward or (iv) a child of a person standing in the place of a parent.
c. The term "spouse" means the statutory or common law husband or wife of an employee.

Please report any future changes regarding the information contained in this form to the Jefferson County Commission Human Resources Department. If additional space is needed, please use the back of this form.

Relationship to Employee
(If child, please state date of birth)

Name of Family Member (print) Relationship Date of Birth Address of Family Member

1. _____
2. _____
3. _____
4. _____
5. _____

I certify that the foregoing information is correct and that I have received Jefferson County Commission Administrative Order 07-02.

Print Name

Department

Signature

SAMPLE

Date

SAMPLE

JEFFERSON COUNTY COMMISSION
FAMILY MEDICAL LEAVE RETURN TO WORK MEDICAL CERTIFICATION



Instructions for the County Employee

1. Complete the top portion of this form.
2. Give it to your health care provider (doctor) to complete the remainder of this form.
3. Submit the completed form to Human Resources.

YOU MAY NOT BE PERMITTED TO RETURN TO WORK UNTIL HUMAN RESOURCES RECEIVES THIS FORM.

Name _____ Job Title _____

Date Your Leave Began SAMPLE Date You Plan to Return to Work _____

Employee Signature _____ Today's Date: _____

TO THE HEALTH CARE PROVIDER

This Medical Certification form is required for the above Jefferson County employee to return to work after a medical leave of absence. Please complete this form and sign below.

Type of Practice _____

Address SAMPLE

Telephone No. _____

Name (please print) _____

I certify that the above named Jefferson County Commission employee is or will be able to resume performing the functions of his/her position on SAMPLE. Please check one of the boxes below:
(Date)

Return to Work – No restrictions.

Return to Work – Restrictions (please describe restrictions below or attach description)

Note: Light duty is only available for employees injured on the job

Health Care Provider's Signature SAMPLE Date _____

Address _____

Telephone Number _____

SAMPLE



Jefferson County Commission

Family Medical Leave Packet – Serious Injury or Illness of Covered Servicemember

Please find enclosed unpaid leave forms you must complete or have your health care provider (doctor, dentist, etc.) complete and return to the Human Resources Department. Below are itemized instructions for each enclosed form. It is important that you follow the instructions and submit completed forms in a timely manner. Incomplete forms will delay the processing of your request.

1. **Employee Request for Family and Medical Leave** – You must complete this form and submit it to Human Resources.
2. **Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave (Family and Medical Leave Act)** – You or the covered servicemember must complete Section I of this form first. After addressing Section I, give the form to the servicemember's health care provider to complete the remainder of the certification (medical). **You are responsible for returning this document to the HR Department as quickly as possible, but not later than 15 calendar days from the date of this letter. Failure to provide the appropriate documentation within 15 calendar days could result in a delay in the commencement of the leave (if not already taken); or a withdrawal of any preliminary designation of FMLA Leave, in which case your leave may be unauthorized, subjecting you to discipline up to and including discharge for an unapproved absence.** Documents may be submitted by FAX to (205) 325-8793.
3. **Authorization to Health Care Provider to Release Medical Documentation** – You must complete Section A of this form and give it to the servicemember's health care provider at the same time you give him/her the Certification for Serious Injury or Illness of Covered Servicemember form.
4. **Benefit Payment Election While on Approved Unpaid Leave** – You must complete this form and return it to HR when you submit the Employee Request for Family and Medical Leave form. Should you have questions regarding payment of benefits, please contact Nakia Buckner at 325-5249.
5. **Family and Medical Leave Family Member Form** – For the purpose of confirming family relationships under the Family and Medical Leave Act (FMLA), in accordance with 29 CFR §825.113(d) you are requested to list the name, relationship to you, and address of each of your living parents, sons, daughters, and spouse.

Should you have questions, please contact Bettie Banks-Coleman at 325-5249.

Regards,

SAMPLE
Bettie Banks-Coleman
Personnel Analyst

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.



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WWW.WAGEHOUR.DOL.GOV



U.S. Wage and Hour Division

SAMPLE

JEFFERSON COUNTY COMMISSION
EMPLOYEE REQUEST FOR FAMILY AND MEDICAL LEAVE
(May be paid or unpaid)



Part A. Employee Information

Employee's Name: SAMPLE Department: _____
(Last) (First) (MI)
Current Address: _____
Work Phone: _____ Home Phone: _____ Cell Phone: _____
Job Title: _____ Hire Date: _____
Employee Appointment Status: _____

Part B. Leave Dates (Continuous or Intermittent)

Estimated Leave Start Date: _____ Estimated Date of Return: _____
 Leave is requested on an intermittent or reduced leave schedule. Indicate the days of the week and/or hours during the day you will be absent: _____

Part C. Reason for Leave

Leave is for my own serious health condition.
 Leave is for the birth of a child or placement of a child for adoption or foster care. Indicate the expected date of birth or placement.
_____ Spouse is employed by the Jefferson County Commission: YES NO
(Date)

Leave is to care for a family member with a serious health condition. Specify the name and relationship of the family member:
_____ (Name) _____ (Relationship to You)

Leave is for a qualifying exigency arising out of the fact that your spouse/ child/ parent is on active duty status in support of a contingency operation as a member of the National Guard or Reserves.
_____ (Name) _____ (Relationship to You)

Leave is to care for a spouse/ child/ parent/ next of kin who is a covered military service member with a serious injury or illness.
_____ (Name) _____ (Relationship to You)

Required medical certification form is attached.
 Documentation to establish required relationship between my family member and me (if applicable) is attached.

SAMPLE
(Signature of Employee or Designee)

(Date)

(If employee is not available to sign request, note verbal conversation above. Include date of the conversation and the signature of the person who completed the form.)

Certification for Serious Injury or
Illness of Covered Servicemember - -
for Military Family Leave (Family and
Medical Leave Act)

Jefferson County Commission
Human Resources Department
Compliance Division



Notice to the EMPLOYER INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a covered servicemember to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave INSTRUCTIONS to the EMPLOYEE or COVERED SERVICEMEMBER: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 C.F.R. § 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave.

Certification for Serious Injury or Illness of Covered Servicemember - - for Military Family Leave (Family and Medical Leave Act)

Jefferson County Commission
Human Resources Department
Compliance Division



SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave: (This section must be completed first before any of the below sections can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name and Address of Employer (this is the employer of the employee requesting leave to care for covered servicemember):

SAMPLE

Name of Employee Requesting Leave to Care for Covered Servicemember:

First Middle Last

Name of Covered Servicemember (for whom employee is requesting leave to care):

First Middle Last

Relationship of Employee to Covered Servicemember Requesting Leave to Care:

Spouse Parent Son Daughter Next of Kin

Part B: COVERED SERVICEMEMBER INFORMATION

(1) Is the Covered Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves? Yes No

If yes, please provide the covered servicemember's military branch, rank and unit currently assigned to:

Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)? Yes No If yes, please provide the name of the medical treatment facility or unit:

(2) Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)? Yes No

Part C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

Describe the Care to Be Provided to the Covered Servicemember and an Estimate of the Leave Needed to Provide the Care:

SAMPLE

SECTION II. For Completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). (Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

SAMPLE

Type of Practice/Medical Specialty: _____

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider: _____

Telephone: () _____ Fax: () _____ Email: _____

PART B: MEDICAL STATUS

(1) Covered Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

(VSI) Very Seriously Ill/Injured – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

(SI) Seriously Ill/Injured – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

OTHER Ill/Injured – a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

NONE OF THE ABOVE (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

(2) Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty in the armed forces? Yes No

(3) Approximate date condition commenced: _____

(4) Probable duration of condition and/or need for care: _____

(5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy? Yes No. If yes, please describe medical treatment, recuperation or therapy:

PART C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

- (1) Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery? Yes No
If yes, estimate the beginning and ending dates for this period of time: _____

- (2) Will the covered servicemember require periodic follow-up treatment appointments? Yes No If yes, estimate the treatment schedule: _____

- (3) Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments? Yes No

- (4) Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? Yes No If yes, please estimate the frequency and duration of the periodic care:

Signature of Health Care Provider: SAMPLE Date: _____

SAMPLE



JEFFERSON COUNTY COMMISSION
BENEFIT PAYMENT ELECTION WHILE ON APPROVED (UNPAID) LEAVE

Form to be completed by Employee and returned to Human Resources with the FMLA Request

Name Department

Current Address Street Address City State Zip Code

Work Phone Home Phone Cell Phone

To continue your current benefits, you must pay your portion of insurance premiums. You can find the amount you owe for insurance coverage monthly on your last two pay stubs. Please indicate the amount you pay per month for insurance below:

Health Insurance, Dental Insurance, Vision Insurance, Voluntary Life, Voluntary Accident, Total Amount

Please make your cashier's check or money order (not personal check) payable to Jefferson County Treasurer and return it with your leave request, or mail the check to the Human Resources Department at:

Jefferson County Human Resources Department
Room A610 - Courthouse Annex
716 Richard Arrington, Jr. Blvd. N.
Birmingham, AL 35203

I have read this information and I understand that the Jefferson County Commission is not responsible for payment of premium of medical / dental / vision insurance or other benefit premiums (i.e., voluntary group term life insurance, voluntary accident insurance) during my approved leave of absence. However, Jefferson County will continue to pay its portion of premiums. Thus, I agree to the following:

- That if I elect to continue coverage under these plans, I will be solely responsible for the payment of my portion of the premiums for such plans.
That if I fail to pay any required premium, my coverage under that plan will end effective the last day of the month for which a premium has been paid.
That if I do not elect to continue my benefits by paying premiums or by failing to pay premiums on time during my approved leave of absence, my eligibility for benefits may be lost.

Employee Signature

Date

SAMPLE



JEFFERSON COUNTY COMMISSION
FAMILY AND MEDICAL LEAVE - FAMILY MEMBER FORM

For the purpose of confirming family relationships under the Family and Medical Leave Act (FMLA), in accordance with 29 CFR §825.113(d) you are requested to list the name, relationship to you, and address of each of your living parents, sons, daughters, and spouse. For the purposes of this form:

- a. The term "parent" means, for FMLA purposes, a person who is or was the biological parent, adoptive parent, stepparent, or foster parent of an employee. This term does not include parents "in law."
b. The term "son or daughter" means, for FMLA purposes, any person who is under 18 years old or any person 18 years old or older who is incapable of self-care because of a mental or physical disability whose relationship to an employee is that of (i) a biological, adopted, or foster child. (ii) a stepchild. (iii) a legal ward or (iv) a child of a person standing in the place of a parent.
c. The term "spouse" means the statutory or common law husband or wife of an employee.

Please report any future changes regarding the information contained in this form to the Jefferson County Commission Human Resources Department. If additional space is needed, please use the back of this form.

Relationship to Employee
(If child, please state date of birth)

Name of Family Member (print) Relationship Date of Birth Address of Family Member

1. _____
2. _____
3. _____
4. _____
5. _____

I certify that the foregoing information is correct and that I have received Jefferson County Commission Administrative Order 07-02.

SAMPLE
Print Name

Department

Signature

Date

SAMPLE



**Jefferson County Commission
Family Medical Leave Packet – Qualifying Exigency for Military Family Leave**

Please find enclosed unpaid leave forms you must complete or have your health care provider (doctor, dentist, etc.) complete and return to the Human Resources Department. Below are itemized instructions for each enclosed form. It is important that you follow the instructions and submit completed forms in a timely manner. Incomplete forms will delay the processing of your request.

1. **Employee Request for Family and Medical Leave** – You must complete this form and submit it to Human Resources.
2. **Certification of Qualifying Exigency for Military Family Leave (Family and Medical Leave Act)** – You must complete Section II of this form. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to active duty status in support of a contingency operation. This documentation may include a copy of the covered military member's active duty orders or other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation. **You are responsible for returning this document to the HR Department as quickly as possible, but not later than 15 calendar days from the date of this letter. Failure to provide the appropriate documentation within 15 calendar days could result in a delay in the commencement of the leave (if not already taken); or a withdrawal of any preliminary designation of FMLA Leave, in which case your leave may be unauthorized, subjecting you to discipline up to and including discharge for an unapproved absence.** Documents may be submitted by FAX to (205) 325-8793.
3. **Benefit Payment Election While on Approved Unpaid Leave** – You must complete this form and return it to HR when you submit the Employee Request for Family and Medical Leave form. Should you have questions regarding payment of benefits, please contact Nakia Buckner at 325-5249.
4. **Family and Medical Leave Family Member Form** – For the purpose of confirming family relationships under the Family and Medical Leave Act (FMLA), in accordance with 29 CFR §825.113(d) you are requested to list the name, relationship to you, and address of each of your living parents, sons, daughters, and spouse.

Should you have questions, please contact Bettie Banks-Coleman at 325-5249.

Regards,

SAMPLE
Bettie Banks-Coleman
Personnel Analyst

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.



For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV



U.S. Wage and Hour Division

SAMPLE

JEFFERSON COUNTY COMMISSION
EMPLOYEE REQUEST FOR FAMILY AND MEDICAL LEAVE
(May be paid or unpaid)



Part A. Employee Information

Employee's Name: _____ Department: _____
(Last) (First) (Middle)
Current Address: _____
Work Phone: _____ Home Phone: _____ Cell Phone: _____
Job Title: _____ Hire Date: _____
Employee Appointment Status: _____

Part B. Leave Dates (Continuous or Intermittent)

Estimated Leave Start Date: _____ Estimated Date of Return: _____
 Leave is requested on an intermittent or reduced leave schedule. Indicate the days of the week and/or hours during the day you will be absent: _____

Part C. Reason for Leave

- Leave is for my own serious health condition.
- Leave is for the birth of a child or placement of a child for adoption or foster care. Indicate the expected date of birth or placement.

(Date) Spouse is employed by the Jefferson County Commission: YES NO
- Leave is to care for a family member with a serious health condition. Specify the name and relationship of the family member:

(Name) (Relationship to You)
- Leave is for a qualifying exigency arising out of the fact that your spouse/ child/ parent is on active duty status in support of a contingency operation as a member of the National Guard or Reserves.

(Name) (Relationship to You)
- Leave is to care for a spouse/ child/ parent/ next of kin who is a covered military service member with a serious injury or illness.

(Name) (Relationship to You)
- Required medical certification form is attached.
- Documentation to establish required relationship between my family member and me (if applicable) is attached.

SAMPLE

(Signature of Employee or Designee)

(Date)

(If employee is not available to sign request, note verbal conversation above. Include date of the conversation and the signature of the person who completed the form.)

Certification of Qualifying Exigency For Military Family Leave (Family and Medical Leave Act)

Jefferson County Commission
Human Resources Department
Compliance Division



SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and while you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.309.

Employer name: _____

Contact Information: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 C.F.R. § 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name: _____
First Middle Last

Name of covered military member on active duty or call to active duty status in support of a contingency operation:

First Middle Last

Relationship of covered military member to you: _____

Period of covered military member's active duty: _____

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to active duty status in support of a contingency operation. Please check one of the following:

- A copy of the covered military member's active duty orders is attached.
- Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.
- I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.

SAMPLE

PART A: QUALIFYING REASON FOR LEAVE

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached. Yes No None Available

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced: _____

Probable duration of exigency: _____

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency? No Yes.

If so, estimate the beginning and ending dates for the period of absence:

3. Will you need to be absent from work periodically to address this qualifying exigency? No Yes.

Estimate schedule of leave, including the dates of any scheduled meetings or appointments: _____

Estimate the frequency and duration of each appointment, meeting, or leave event including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours _____ day(s) per event.

SAMPLE



JEFFERSON COUNTY COMMISSION
BENEFIT PAYMENT ELECTION WHILE ON APPROVED (UNPAID) LEAVE

Form to be completed by Employee and returned to Human Resources with the FMLA Request

Name (Please Print) SAMPLE Department

Current Address Street Address City State Zip Code

Work Phone Home Phone Cell Phone

To continue your current benefits, you must pay your portion of insurance premiums. You can find the amount you owe for insurance coverage monthly on your last two pay stubs. Please indicate the amount you pay per month for insurance below:

\$ Health Insurance \$ Voluntary Life
\$ Dental Insurance \$ Voluntary Accident
\$ Vision Insurance \$ Total Amount

Please make your cashier's check or money order (not personal check) payable to Jefferson County Treasurer and return it with your leave request, or mail the check to the Human Resources Department at:

Jefferson County Human Resources Department
Room A610 - Courthouse Annex
716 Richard Arrington, Jr. Blvd. N.
Birmingham, AL 35203

I have read this information and I understand that the Jefferson County Commission is not responsible for payment of premium of medical / dental / vision insurance or other benefit premiums (i.e., voluntary group term life insurance, voluntary accident insurance) during my approved leave of absence. However, Jefferson County will continue to pay its portion of premiums. Thus, I agree to the following:

- That if I elect to continue coverage under these plans, I will be solely responsible for the payment of my portion of the premiums for such plans.
That if I fail to pay any required premium, my coverage under that plan will end effective the last day of the month for which a premium has been paid.
That if I do not elect to continue my benefits by paying premiums or by failing to pay premiums on time during my approved leave of absence, my eligibility for benefits may be lost.

Employee Signature SAMPLE

Date

SAMPLE



JEFFERSON COUNTY COMMISSION
FAMILY AND MEDICAL LEAVE - FAMILY MEMBER FORM

For the purpose of confirming family relationships under the Family and Medical Leave Act (FMLA), in accordance with 29 CFR §825,113(d) you are requested to list the name, relationship to you, and address of each of your living parents, sons, daughters, and spouse. For the purposes of this form:

- a. The term "parent" means, for FMLA purposes, a person who is or was the biological parent, adoptive parent, stepparent, or foster parent of an employee. This term does not include parents "in law."
b. The term "son or daughter" means, for FMLA purposes, any person who is under 18 years old or any person 18 years old or older who is incapable of self-care because of a mental or physical disability whose relationship to an employee is that of (i) a biological, adopted, or foster child, (ii) a stepchild, (iii) a legal ward or (iv) a child of a person standing in the place of a parent.
c. The term "spouse" means the statutory or common law husband or wife of an employee.

Please report any future changes regarding the information contained in this form to the Jefferson County Commission Human Resources Department. If additional space is needed, please use the back of this form.

Relationship to Employee
(if child, please state date of birth)

Table with 4 columns: Name of Family Member (print), Relationship, Date of Birth, Address of Family Member. Rows 1-5.

I certify that the foregoing information is correct and that I have received Jefferson County Commission Administrative Order 07-02.

Print Name: SAMPLE
Signature
Date

Department

**JEFFERSON COUNTY COMMISSION
REQUEST FOR AUTHORIZED LEAVE (Excluding FMLA)**

Name _____

Hire Date _____

Date _____

Department _____

I request time off for:

Appointment Status

Administrative Leave

Probationary (less than one year service)

Career Development*

Provisional

Extended Medical/Disability Leave *

Permanent (one year or more service)

Military Leave

Promotional Probationary (one year or more service)

Personal Leave *

Other _____

Granted Leave Without Pay (Comment): _____

(Please indicate the total number of hours being requested.)

*Career Development, Extended Medical/Disability, and Personal Leaves must be accompanied by a memo from the employee's Department Head to the Director of Human Resources, Demetruis Taylor, detailing how the employee's duties will be covered during their absence.

UNPAID LEAVE _____ to _____ RETURN DATE _____

PAID LEAVE _____ to _____ RETURN DATE _____

Previously Approved: (current year)

_____ # of PAID SICK HOURS TAKEN

_____ # of PAID VACATION HOURS TAKEN

_____ # of PAID VACATION/SICK HOURS APPROVED, BUT NOT YET TAKEN (e.g., Christmas holidays)

_____ # of UNPAID HOURS TAKEN

Please do not make any plans until management grants your request. Jefferson County reserves the right to deny requests based on business needs.

Employee's Signature _____

Date _____

Departmental Use Only

APPROVAL/DENIAL - *Please include a memo from the Department Head to Demetruis Taylor, Human Resources Director, detailing the rationale for the recommendation. If approval is recommended, the memo must state that there will be no use of overtime or temporary agency personnel.

Department Head Recommendation Approve Deny Comments _____

Department Head Signature _____ Date _____

Fax to Human Resources: (205) 325-8793